Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS430AGC	A. BUILDING _____ B. WING _____	C 07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME	**3970 MARYLAND AVE LAS VEGAS, NV 89121**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 05/28/10 and 7/30/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled person and or persons with mental retardation, Category II residents . The census at the time of the survey was six. Complaint #NV00025449 unsubstantiated. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this report for your records.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE